MDR Tracking Number: M5-04-0668-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on October 31, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the therapeutic exercises, massage therapy and electrical stimulation-unattended were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above was not found to be medically necessary, reimbursement for dates of service from 04-07-03 to 04-11-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 15th day of March 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

March 12, 2004

Re: IRO Case # M5-04-0668

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is board Certified in Orthopedic Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History
The patient injured his left knee on ___, and reportedly underwent arthroscopic surgery on October 2001. He continued to suffer from chronic left knee pain and was treated with anti inflammatory medication and physical therapy. The patient was diagnosed with patellar chondral tearing. The patient's subjective symptoms were becoming worse after surgery. The patient was diagnosed with Reflex Sympathetic Dystrophy and was treated with physical therapy and sympathetic nerve blocks. On 12/18/02 arthroscopic surgery of the left knee was performed with thermal shrinking of the ACL and open lateral retinacular release. Following surgery the patient was referred to physical therapy. The patient's initial physical therapy evaluation was 2/5/03. From 2/10/03 to 4/4/03 the patient completed 30 treatment sessions with the physical therapist. Physical therapy treatment sessions were continued from 4/7/03 to 4/11/03. These sessions included therapeutic exercises, massage therapy and some electrical stimulation.

Requested Service(s)
Therapeutic exercises, massage therapy, electrical stimulation-unattended 4/7/03-4/11/03

Decision
I agree with the carrier's decision to deny the requested services.

Rationale
The patient's injury occurred on ___. He underwent two surgical procedures with an extensive physical therapy program between he first and second operation. After the second operation on 12/18/02 the patient underwent physical therapeutic exercises on a daily basis. He attended 25 sessions over a period of two months. Considering the injury and the type of surgical procedure, physical therapy was indicated following arthoscopic surgery. Physical therapy three times per week for six to eight weeks maximum is recommended after arthroscopic knee surgery. In this case, the patient demonstrated significant improvement after the first 18 sessions. Based on the records provided for this review, the patient had had ample therapy sessions to progress to a home exercise program and continue his rehabilitation on his own.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.